HOUSE BILL No. 1596

DIGEST OF INTRODUCED BILL

Citations Affected: IC 12-7-2; IC 12-15; IC 12-17.6-2-9.

Synopsis: Public assistance case management and copayment issues. Eliminates the primary care case management program in the Medicaid program and in the children's health insurance program (CHIP). Requires the office of Medicaid policy and planning to apply to the United States Department of Health and Human Services for a waiver to charge higher copayments to Medicaid recipients for emergency room visits in which only nonemergency services were provided.

Effective: Upon passage; July 1, 2005.

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January 18, 2005, read first time and referred to Committee on Public Health.

Introduced

First Regular Session 114th General Assembly (2005)

PRINTING CODE. Amendments: Whenever an existing statute (or a section of the Indiana Constitution) is being amended, the text of the existing provision will appear in this style type, additions will appear in **this style type**, and deletions will appear in ~~this style type.~~

Additions: Whenever a new statutory provision is being enacted (or a new constitutional provision adopted), the text of the new provision will appear in **this style type**. Also, the word **NEW** will appear in that style type in the introductory clause of each SECTION that adds a new provision to the Indiana Code or the Indiana Constitution.

Conflict reconciliation: Text in a statute in *this style type* or ~~*this style type*~~ reconciles conflicts between statutes enacted by the 2004 Regular Session of the General Assembly.

HOUSE BILL No. 1596

A BILL FOR AN ACT to amend the Indiana Code concerning Medicaid.

Be it enacted by the General Assembly of the State of Indiana:

SECTION 1. IC 12-7-2-144.8 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2005]: **Sec. 144.8. "Primary care case management program", for purposes of IC 12-15 and IC 12-17.6, means a delivery system for health care in which members are linked to a primary medical provider who:**

(1) contracts directly, respectively, with the office of Medicaid policy and planning or the office of the children's health insurance program; and

(2) is responsible for coordinating designated covered services for a recipient.

SECTION 2. IC 12-7-2-169.7 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2005]: **Sec. 169.7. "Risk based managed care program", for purposes of IC 12-15 and IC 12-17.6, means a fully capitated prepayment plan where a managed care organization, under a contract with the office of Medicaid policy and planning or**

the office of the children's health insurance program, respectively, is at risk to arrange for and administer the provision of a comprehensive set of covered services to individuals.

SECTION 3. IC 12-15-12-1.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2005]: **Sec. 1.5. (a) As used in this article, "managed care" refers to the risk based managed care program.**

(b) The office may not operate a Medicaid primary care case management program.

SECTION 4. IC 12-15-12-2 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2005]: Sec. 2. Except as provided in sections 8 and 9 of this chapter, a Medicaid recipient **who participates in the risk based managed care program** may receive physician services from a managed care provider selected by the recipient from a list of managed care providers furnished the recipient by the office.

SECTION 5. IC 12-15-12-15 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2005]: Sec. 15. ~~The office, for purposes of the primary care case management program, and~~ A managed care contractor, for purposes of the risk based managed care program, shall:

(1) cover and pay for all medically necessary screening services provided to an individual who presents to an emergency department with an emergency medical condition; and

(2) beginning July 1, 2001, ~~not~~ **neither** deny ~~or~~ **nor** fail to process a claim for reimbursement for emergency services on the basis that the enrollee's primary care provider's authorization code for the services was not obtained before or after the services were rendered.

SECTION 6. IC 12-15-12-17 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2005]: Sec. 17. (a) This section applies to post-stabilization care services provided to an individual enrolled in

~~(1)~~ the Medicaid risk based managed care program. ~~or~~

~~(2) the Medicaid primary care case management program.~~

(b) The ~~office, if the individual is enrolled in the primary care case management program, or the~~ managed care organization ~~if the individual is enrolled in the risk-based managed care program,~~ is financially responsible for the following services provided to an enrollee:

(1) Post-stabilization care services that are preapproved by ~~a representative of the office or~~ the managed care organization. ~~as~~

~~applicable.~~

(2) Post-stabilization care services that are not preapproved by ~~a representative of the office or~~ the managed care organization ~~as applicable,~~ but that are administered to maintain the enrollee's stabilized condition within one (1) hour of a request to ~~the office or~~ the managed care organization for preapproval of further post-stabilization care services.

(3) Post-stabilization care services provided after an enrollee is stabilized that are not preapproved by ~~a representative of the office or~~ the managed care organization ~~as applicable,~~ but that are administered to maintain, improve, or resolve the enrollee's stabilized condition if ~~the office or~~ the managed care organization:

(A) does not respond to a request for preapproval within one (1) hour;

(B) cannot be contacted; or

(C) cannot reach an agreement with the enrollee's treating physician concerning the enrollee's care, and a physician representing ~~the office or~~ the managed care organization ~~as applicable,~~ is not available for consultation.

(c) If the conditions described in subsection (b)(3)(C) exist, ~~the office or~~ the managed care organization ~~as applicable,~~ shall give the enrollee's treating physician an opportunity to consult with a physician representing ~~the office or~~ the managed care organization. The enrollee's treating physician may continue with care of the enrollee until a physician representing ~~the office or~~ the managed care organization ~~as applicable,~~ is reached or until one (1) of the following criteria is met:

(1) A physician:

(A) representing ~~the office or~~ the managed care organization; ~~as applicable;~~ and

(B) who has privileges at the treating hospital;

assumes responsibility for the enrollee's care.

(2) A physician representing ~~the office or~~ the managed care organization ~~as applicable,~~ assumes responsibility for the enrollee's care through transfer.

(3) A representative of ~~the office or~~ the managed care organization ~~as applicable,~~ and the treating physician reach an agreement concerning the enrollee's care.

(4) The enrollee is discharged from the treating hospital.

(d) This subsection applies to post-stabilization care services provided under subsection (b)(1), (b)(2), and (b)(3) to an individual enrolled in the Medicaid risk based managed care program by a

provider who has not contracted with a Medicaid risk based managed care organization to provide post-stabilization care services under subsection (b)(1), (b)(2), and (b)(3) to the individual. Payment for post-stabilization care services provided under subsection (b)(1), (b)(2), and (b)(3) must be in an amount equal to one hundred percent (100%) of the current Medicaid fee for service reimbursement rates for such services.

(e) This section does not prohibit a managed care organization from entering into a subcontract with another Medicaid risk based managed care organization providing for the latter organization to assume financial responsibility for making the payments required under this section.

(f) This section does not limit the ability of ~~the office or~~ the managed care organization to:

(1) review; and

(2) make a determination of;

the medical necessity of the post-stabilization care services provided to an enrollee for purposes of determining coverage for such services.

SECTION 7. IC 12-15-15-2.5 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2005]: Sec. 2.5. (a) Payment for physician services provided in the emergency department of a hospital licensed under IC 16-21 must be at a rate of one hundred percent (100%) of rates payable under the Medicaid fee structure.

(b) The payment under subsection (a) must be calculated using the same methodology used for all other physicians participating in the Medicaid program.

(c) For services rendered and documented in an individual's medical record, physicians must be reimbursed for federally required medical screening exams that are necessary to determine the presence of an emergency using the appropriate Current Procedural Terminology (CPT) codes 99281, 99282, or 99283 described in the Current Procedural Terminology Manual published annually by the American Medical Association, without authorization by the enrollee's primary medical provider.

~~(d) Payment for all other physician services provided in an emergency department of a hospital to enrollees in the Medicaid primary care case management program must be at a rate of one hundred percent (100%) of the Medicaid fee structure rates, provided the service is authorized, prospectively or retrospectively, by the enrollee's primary medical provider.~~

~~(c)~~ **(d)** This section does not apply to a person enrolled in the Medicaid risk based managed care program.

SECTION 8. IC 12-15-35-28, AS AMENDED BY P.L.28-2004, SECTION 104, AND AS AMENDED BY P.L.97-2004, SECTION 51, IS CORRECTED AND AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2005]: Sec. 28. (a) The board has the following duties:

(1) The adoption of rules to carry out this chapter, in accordance with the provisions of IC 4-22-2 and subject to any office approval that is required by the federal Omnibus Budget Reconciliation Act of 1990 under Public Law 101-508 and its implementing regulations.

(2) The implementation of a Medicaid retrospective and prospective DUR program as outlined in this chapter, including the approval of software programs to be used by the pharmacist for prospective DUR and recommendations concerning the provisions of the contractual agreement between the state and any other entity that will be processing and reviewing Medicaid drug claims and profiles for the DUR program under this chapter.

(3) The development and application of the predetermined criteria and standards for appropriate prescribing to be used in retrospective and prospective DUR to ensure that such criteria and standards for appropriate prescribing are based on the compendia and developed with professional input with provisions for timely revisions and assessments as necessary.

(4) The development, selection, application, and assessment of interventions for physicians, pharmacists, and patients that are educational and not punitive in nature.

(5) The publication of an annual report that must be subject to public comment before issuance to the federal Department of Health and Human Services and to the Indiana legislative council by December 1 of each year. The report *issued* to the legislative council must be in an electronic format under IC 5-14-6.

(6) The development of a working agreement for the board to clarify the areas of responsibility with related boards or agencies, including the following:

(A) The Indiana board of pharmacy.

(B) The medical licensing board of Indiana.

(C) The SURS staff.

(7) The establishment of a grievance and appeals process for physicians or pharmacists under this chapter.

(8) The publication and dissemination of educational information to physicians and pharmacists regarding the board and the DUR program, including information on the following:

(A) Identifying and reducing the frequency of patterns of fraud, abuse, gross overuse, or inappropriate or medically unnecessary care among physicians, pharmacists, and recipients.

(B) Potential or actual severe or adverse reactions to drugs.

(C) Therapeutic appropriateness.

(D) Overutilization or underutilization.

(E) Appropriate use of generic drugs.

(F) Therapeutic duplication.

(G) Drug-disease contraindications.

(H) Drug-drug interactions.

(I) Incorrect drug dosage and duration of drug treatment.

(J) Drug allergy interactions.

(K) Clinical abuse and misuse.

(9) The adoption and implementation of procedures designed to ensure the confidentiality of any information collected, stored, retrieved, assessed, or analyzed by the board, staff to the board, or contractors to the DUR program that identifies individual physicians, pharmacists, or recipients.

(10) The implementation of additional drug utilization review with respect to drugs dispensed to residents of nursing facilities shall not be required if the nursing facility is in compliance with the drug regimen procedures under 410 IAC 16.2-3-8 and 42 CFR 483.60.

(11) The research, development, and approval of a preferred drug list for

~~(A)~~ Medicaid's fee for service program

~~(B) Medicaid's primary care case management program; and~~

~~(C) the primary care case management component of the children's health insurance program under IC 12-17.6;~~

in consultation with the therapeutics committee.

(12) The approval of the review and maintenance of the preferred drug list at least two (2) times per year.

(13) The preparation and submission of a report concerning the preferred drug list at least two (2) times per year to the select joint commission on Medicaid oversight established by IC 2-5-26-3.

(14) The collection of data reflecting prescribing patterns related to treatment of children diagnosed with attention deficit disorder or attention deficit hyperactivity disorder.

(15) Advising the Indiana comprehensive health insurance association established by IC 27-8-10-2.1 concerning implementation of chronic disease management and

pharmaceutical management programs under IC 27-8-10-3.5.

(b) The board shall use the clinical expertise of the therapeutics committee in developing a preferred drug list. The board shall also consider expert testimony in the development of a preferred drug list.

(c) In researching and developing a preferred drug list under subsection (a)(11), the board shall do the following:

(1) Use literature abstracting technology.

(2) Use commonly accepted guidance principles of disease management.

(3) Develop therapeutic classifications for the preferred drug list.

(4) Give primary consideration to the clinical efficacy or appropriateness of a particular drug in treating a specific medical condition.

(5) Include in any cost effectiveness considerations the cost implications of other components of the state's Medicaid program and other state funded programs.

(d) Prior authorization is required for coverage under a program described in subsection (a)(11) of a drug that is not included on the preferred drug list.

(e) The board shall determine whether to include a single source covered outpatient drug that is newly approved by the federal Food and Drug Administration on the preferred drug list not later than sixty (60) days after the date on which the manufacturer notifies the board in writing of the drug's approval. However, if the board determines that there is inadequate information about the drug available to the board to make a determination, the board may have an additional sixty (60) days to make a determination from the date that the board receives adequate information to perform the board's review. Prior authorization may not be automatically required for a single source drug that is newly approved by the federal Food and Drug Administration, and that is:

(1) in a therapeutic classification:

(A) that has not been reviewed by the board; and

(B) for which prior authorization is not required; or

(2) the sole drug in a new therapeutic classification that has not been reviewed by the board.

(f) The board may not exclude a drug from the preferred drug list based solely on price.

(g) The following requirements apply to a preferred drug list developed under subsection (a)(11):

(1) Except as provided by IC 12-15-35.5-3(b) and IC 12-15-35.5-3(c), the office or the board may require prior authorization for a drug that is included on the preferred drug list

under the following circumstances:

(A) To override a prospective drug utilization review alert.

(B) To permit reimbursement for a medically necessary brand name drug that is subject to generic substitution under IC 16-42-22-10.

(C) To prevent fraud, abuse, waste, overutilization, or inappropriate utilization.

(D) To permit implementation of a disease management program.

(E) To implement other initiatives permitted by state or federal law.

(2) All drugs described in IC 12-15-35.5-3(b) must be included on the preferred drug list.

(3) The office may add a drug that has been approved by the federal Food and Drug Administration to the preferred drug list without prior approval from the board.

(4) The board may add a drug that has been approved by the federal Food and Drug Administration to the preferred drug list.

(h) At least two (2) times each year, the board shall provide a report to the select joint commission on Medicaid oversight established by IC 2-5-26-3. The report must contain the following information:

(1) The cost of administering the preferred drug list.

(2) Any increase in Medicaid physician, laboratory, or hospital costs or in other state funded programs as a result of the preferred drug list.

(3) The impact of the preferred drug list on the ability of a Medicaid recipient to obtain prescription drugs.

(4) The number of times prior authorization was requested, and the number of times prior authorization was:

(A) approved; and

(B) disapproved.

(i) The board shall provide the first report required under subsection (h) not later than six (6) months after the board submits an initial preferred drug list to the office.

SECTION 9. IC 12-17.6-2-9 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2005]: Sec. 9. (a) The office shall incorporate creative methods, reflective of community level objectives and input, to do the following:

(1) Encourage beneficial and appropriate use of health care services.

(2) Pursue efforts to enhance provider availability.

(b) In determining the best approach for each area, the office shall

do the following:

(1) Evaluate distinct market areas.

(2) Weigh the advantages and disadvantages of ~~alternative delivery models.~~ ~~including the following:~~

~~(A) Risk based managed care only.~~

~~(B) Primary care gatekeeper model only.~~

~~(C) A combination of clauses (A) and (B).~~

a fee for service program in comparison to a risk based managed care program.

(c) The office may not operate a primary care case management program.

SECTION 10. [EFFECTIVE UPON PASSAGE] **(a) As used in this SECTION, "office" refers to the office of Medicaid policy and planning established by IC 12-8-6-1.**

(b) A contract or provider agreement relating to a primary care case management program may not be entered into or renewed after June 30, 2005.

(c) The office shall establish a plan not later than July 1, 2005, to transfer recipients from a primary care case management program to either the fee for service program or the risk based managed care program at the earliest possible time after June 30, 2005.

SECTION 11. [EFFECTIVE JULY 1, 2005] **(a) As used in this SECTION, "office" refers to the office of Medicaid policy and planning established by IC 12-8-6-1.**

(b) The office shall apply to the United States Department of Health and Human Services for a waiver under the state Medicaid program from the requirement that cost sharing charges be nominal when nonemergency services are furnished in a hospital emergency room to a Medicaid recipient.

(c) The office shall request in the waiver applied for under subsection (b) that a Medicaid recipient be charged the following copayments for an emergency room visit in which only nonemergency services were provided:

(1) Twenty dollars ($20) for the recipient's first emergency room visit.

(2) Twenty-five dollars ($25) for the recipient's second emergency room visit in a calendar month.

(3) Fifty dollars ($50) for the recipient's third emergency room visit in a calendar month.

(4) Twenty-five dollars ($25) for the fourth visit and any subsequent visit by the recipient in a calendar month.

(d) If the United States Department of Health and Human Services denies the copayment schedule set forth in subsection (c), the office shall resubmit the waiver request with a revised copayment schedule.

(e) The office may not implement the waiver until the office files an affidavit with the governor attesting that the waiver applied for under this SECTION is in effect. The office shall file the affidavit under this subsection not later than five (5) days after the office is notified by the United States Department of Health and Human Services that the waiver is approved.

(f) If the office receives approval for the waiver under this SECTION and the governor receives the affidavit filed under subsection (e), the office shall implement the waiver not more than sixty (60) days after the governor receives the affidavit.

(g) The office may adopt rules under IC 4-22-2 necessary to implement this SECTION.

(h) This SECTION expires December 31, 2012.

SECTION 12. **An emergency is declared for this act.**